Mr & Mrs T F Chon

Parkside Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 12 July 2016 and was unannounced. An inspection took place on 5 January 2016. At that inspection we found the home was in breach of seven legal requirements and regulation associated with the Health and Social Care Act 2008. We found that risk assessments were not in place for people to protect people from harm and medicines were not being managed safely. Mental capacity training and assessment had not been carried out in accordance to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) application had not been made to deprive people of their liberty lawfully. We also found that supervisions and training were not being carried out consistently. Some people's food was not being monitored and actions plans were not in place for people at risk of losing weight. Some care plans had not been completed in full.

Parkside Residential Home is a residential home for up to 30 adults with dementia and mental health needs. There were 27 people staying there at the time of the inspection.

The home did not have a registered manager in place during our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The home had a manager in place and the provider told us that the manager will be applying for registration.

People were put at risk of harm as improvements had not been made with medicines. Medicines were not being managed safely. We found that some medicines were not stored and disposed safely, service users Medicine Administration Records (MAR) were not always completed in full or accurately and medicine were not being followed as instructed on people's MAR. We found two people had received an overdose of their medicine and action had not been taken immediately. Internal medicines audits had not been carried out. An external medicine audit, carried out by a pharmacist in February 2016 that identified the shortfalls we found on this inspection had not been addressed.

We found some improvements had been made with identifying and assessing risks to people. Assessments had been made specific to some people's circumstances and health conditions. However, we still found that some risk assessments had not been identified or completed in full during the inspection.

Some people, relatives and staff raised concerns with staffing levels. Comprehensive systems were not in place to calculate staffing levels contingent with people's dependency levels. The role of the manager combined managerial and significant caring duties had an impact on the ability of a manager to manage the service.

Improvements had not been made in assessing people's capacity to make decisions on a particular area. MCA assessment had not been carried out for three people out of the nine care plans we looked at. Where

people had been deemed to lack or have capacity, the assessment did not record what area people lacked or had capacity in. Staff still had not received MCA and Deprivation of Liberty Safeguarding (DoLS) training. Two staff were not able to tell us about the principles of the MCA and how the test was applied to determine if a person had capacity to make a specific decision about their care.

DoLS applications had been made to deprive people of their liberty lawfully in order to ensure people's safety. Outcomes of the DoLS application were not sent to the CQC.

We did not find food was being monitored for three people with specific health concerns to ensure they had a healthy balanced diet. Blood level was not being monitored and recorded for two people. One person required weekly weight monitoring, we found the person's weight was not being monitored and recorded weekly. One person's fluid intake was not being monitored to prevent the risk of infection.

Some improvements had been made with supervisions. Appraisals were carried out with staff but this did not cover training, objectives and development needs. Recent supervisions took place with staff members.

Not all of the staff working at the home had received the training they needed to do their jobs effectively. Staff had received induction when starting employment.

Some care plans were inconsistent and were not completed in full.

An action plan of the breaches identified at the last inspection was not sent to the CQC.

We did not find evidence that quality assurance monitoring was being carried out, that would have helped identify the shortfalls we found during the inspection. Surveys were carried out but was not analysed to ensure people received high quality care therefore there was no culture of continuous improvement.

Some of the shortfalls found at our last inspection with medicines, nutrition, risk assessments, MCA and person centred care had not been addressed in full.

Staff were aware on how to manage complaints and we found most complaints were investigated. Two complaints had not been investigated, the provider told us this was investigated by the previous manager but the actions were not recorded.

People told us they felt safe. Staff knew how to keep people safe from abuse. They knew how to recognise abuse and who to report to and understood how to whistle blow. Whistleblowing is when someone who works for an employer raises a concern which harms, or creates a risk of harm, to people who use the service.

Recruitment and selection procedures were in place. Checks had been undertaken to ensure staff were suitable for the role.

We observed caring and friendly interactions between people, management and staff. There was an activities programme in place.

People were encouraged to be independent. People were able to go to their rooms and move freely around the house.

Overall, we found significant shortfalls in the care provided to people. We identified breaches of regulations

relating to consent, risk management, medicines, staffing, person centred care, nutrition and hydration, complaints, notifications, record keeping and quality assurance.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, the service will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Some aspects of the service were not safe.

Medicines were not being managed safely and people were at risk of harm.

Some risk assessments were not updated to reflect people's current circumstances and health needs.

Comprehensive systems were not in place to calculate staffing levels contingent with people's dependency levels. The manager provided support and care to people combined with managerial duties.

Staff knew how to identify abuse and the correct procedure to follow to report abuse.

Recruitment procedures were in place to ensure staff members were fit to undertake their roles.

Checks had been made by qualified professionals to ensure the premises was safe.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

People's rights were not being consistently upheld in line with the Mental Capacity Act 2005 (MCA). Staff had not been trained in MCA and Deprivation of Liberty Safeguards. Two staff were not able to tell us about the principles of the MCA. DoLS application had been made.

One person's weight was not being monitored consistently. Fluid intake was not being monitored for one person with specific health concerns. Food intake was not being monitored for three people with specific health concerns.

Not all staff had received mandatory training required to perform their roles.

Recent supervisions were carried out with staff. Appraisals that

were carried out did not identify concerns and training needs.

People had access to healthcare.

Is the service caring?

Good

The service was caring.

There were positive relationships between staff and people using the service. Staff treated people with respect and dignity.

People were encouraged to be independent.

Staff had a good knowledge and understanding on people's background and preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans were not completed in full and did not include people's care and support needs.

Most complaints were managed and investigated in full since the last inspection. Some people and relatives told us they had raised concerns but this was not investigated. Two complaints received did not include the actions taken by the home.

There was an activities programme in place and activities were available for people using the service and people were observed interacting and enjoying the activities.

Is the service well-led?

Inadequate

The service was not always well led.

The provider did not submit an action plan following the breaches identified at the last inspection.

The provider did not submit required statutory notifications to CQC such as DoLS outcome.

Regular audits were not being carried out that would have helped identify the shortfalls we found during the inspection.

Surveys were not analysed and used to ensure people received high quality care. There was not a culture of continuous improvement.

Accurate, complete and contemporaneous records had not been kept. People, relatives and staff were generally positive about the manager. Staff and residents meetings were being held.	

Parkside Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was carried out on 12 July 2016 and was unannounced. The inspection team comprised of one inspector, a specialist advisor in nursing and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed relevant information that we had about the provider including any notifications of safeguarding or incidents affecting the safety and wellbeing of people. We also made contact with the local authority for any information they had that was relevant to the inspection.

During the inspection we spoke with seven people, three relatives, one health professional, four staff, the manager and the provider. We observed interactions between people and staff members to ensure that the relationship between staff and the people was positive and caring. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people when they may not be able to tell us themselves.

We spent some time looking at documents and records that related to people's care and the management of the home. We looked at nine care plans, which included risk assessments.

We reviewed five staff files which included training and supervision records. We looked at other documents held at the home such as medicine records, premises safety records and residents meeting minutes.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at the service and had no concerns. One person told us, "Yes I feel pretty safe here" and another person commented, "Yes, I do" when asked if they felt safe. A relative commented, "I have never seen the staff treat the residents with disrespect." A health professional told us, "Residents are happy." A staff member said, "Residents really like it here." Despite these positive comments we found that aspects of the service were not safe.

During out last inspection the service was in breach of Regulation 12(2)(g) of the of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014 as we found medicines were not being managed safely.

During this inspection we still found that medicines were not being managed safely and people were being put at risk of harm. We found that some medicines were not stored and disposed safely, people's Medicines Administration Records (MAR) were not always completed in full or accurately and medicines being signed for as administered was not given. Internal medicines audits had not been carried out and the external medicine audit carried out by a pharmacist in February 2016 that identified majority of the shortfalls we found had not been addressed.

Senior staff and the manager did not have current medicine training and their competencies had not been tested annually. The homes medicine policy, last updated in February 2016, stated medicines must always be administered by a senior care assistant or by a designated appropriately trained and competent member of staff. The staff we spoke to could not demonstrate the basic requirements of safe medicines management.

Medicines were not always administered safely. We observed the medicine round during the morning and observed more than one person's medicine outside the medicines trolley. Medicines prepared for one person was left on the top of the trolley while the staff member prepared another person's medicine on the breakfast table. Liquid medicines were not being measured accurately. The staff member used pods to measure liquids. These pods are filled mechanically in pharmacies by machine with liquids at pre-calibrate dose. They were not designed for measuring liquids manually and had no graduated measurement marking on them. The staff member told us they had no medicines measuring spoons. We later found a supply of measuring spoons in the medicines room. A person who had been left with their medicines approached the staff member stating they could not swallow paracetamol tablets as they stuck in their throat. The staff member stated "just try". In another instance, a staff returned a medicine to the staff member administering the medicines because the person could not swallow it. The medicine was Calcichew and should be chewed not swallowed. This warning had not been added to the person's MAR chart.

During the inspection we noted it was only the second day of the current medicine cycle. New MAR charts had been provided for the week commencing 11 July 2016. During the course of the morning, a person's son arrived to take the person to the hospital. The person's MAR could not initially be located and the person's medicine could not be administered. This and another person's hand written MAR had not been moved forward with the new month's MAR charts. The person's MAR was located but on unpacking the person's

medicines, some medicines were not boxed or labelled. The hand written MAR chart had been prepared at the end of June and medicines were being administered without the prescriber's intention documented on the label. One person who had been in the home for several weeks had medicines in use with a hand written MAR. We found one medicine had no dose on what was required. Therefore there was a risk that without the prescriber's intention documented on the label, the correct dosage of medicine may not be administered.

Checking MAR against the label is part of the safe medicine process. This and other hand transcribed MAR charts were of poor quality as none recorded quantity of medicines booked in. Some medicines had no information about the dose to be given and some medicines did not have any of the warning labels or statutory recommendations added. The records were not being completed in line with NICE guidance for medicines management in care homes.

Medicine were not being followed as instructed on people's MAR therefore some people did not receive the correct dosage and had missed their medicines. A medicine due to be given on 5 July 2016 was given on 4 July 2016. The medicine was missed on 11 July 2016 as the medicine was not in stock. The manager had been trying to register the person with a GP but was not aware that a pharmacy could provide an emergency supply or an emergency prescription could be requested from 111. Therefore the person had gone without this medicine. A person had a hand written MAR including a medicine with a hand written note to give half as directed by the GP. On the day of the inspection the manager confirmed she had given the person the whole tablet because she could not half it.

For one person we found a medicine that was to be given once a week on a Monday was administered on Monday 13 June 2016 and Tuesday 14 June 2016 on two consecutive days. There was no evidence that the incident had been reviewed to establish if the two doses given on two consecutive days was a recording error or if a GP was consulted for advice to determine if this would impact on the person's health after the error was made. Therefore there was a risk that the person may have received an incorrect dosage, which could have an impact on the person's health.

We found 10 instances in people's MAR charts where staff had not signed to confirm that people had received their medicines. For one person we found that medicines had been signed for as administered between 2 and 10 July 2016 but was not given and stored on the returned box. A person told us, "I was prescribed iron tablets for my low blood count but never got them. Even my eyes are now itching." Another person told us, "On Saturday night they are supposed to give tablets at 22:00. But sometimes it is 19:00, other times it is completely forgotten and I only get them if I remind them. Other times the tablets are left on the side for me to take them." Therefore there was a risk that people had not received their medicines. We were informed that medicines had been administered but staff may have forgotten to sign people's MAR.

The manager could not locate the controlled cupboard key therefore we could not check the content of the cupboard and establish the balances in stock matched those recorded in the register. Review of the control drug register (CDR) documented that the correct process with regards to record keeping had not been applied. There were pages with no name of the medicine, the strength and its form. Entries where a controlled drug had been administered had no date or time added or the amount that was administered.

The home did not always effectively record medicines received in the home. On the day of the inspection in the manager's office, which was open access to all, a plastic box with non biodose medicines, that is a monitored dosage accommodating tablets and liquid for the new cycle had not yet been booked in or safely stored. We were informed that the medicines were due to be recorded and had arrived on the day. There was no evidence to confirm this. The provider's medicines policy stated, 'The home makes sure that records are kept of all medicines ordered'.

Medicines were not always stored securely. The medicines refrigerator was not locked; however, the medicines room was locked. The provider's medicines policy stated, 'All medication within the home is safely stored away including blister packs, non-prescription medication, the keys to the medicines trolley are always kept by the senior or manager. The trolley is never left unlocked or unattended and when not in use is secured to a wall.' However, the keys to the medicines trolley were left in open access on top of the unattended trolley on two occasions. The medicines trolley was not secured to a wall.

The temperature of the medicines refrigerator and medicines room were not being recorded. The home was unable to demonstrate whether the refrigerator had stayed within the temperature ranges advised by the medicines manufacturers. The fridge was not locked and was in need of defrosting due to build-up of ice. Ventolin inhalers had been placed in the fridge, which did not meet the manufacture's recommendations. The provider told us after the inspection the fridge had been de-frosted and medicines that did not meet the manufactures guidance had been removed.

The medicines room had multiple boxes of medicines to be returned dating back to March 2016. There was a plastic bag with a large number of discarded capsules and tablets. We were advised that these were refused medicines but there was no information in relation to the person the medicines belonged to or over what period they had been accumulated. No explanation could be provided on why the medicines had not been returned. There was no paperwork to show medicines that needed to be returned.

We found that some people self-administered all or some of their medicines. However, there were no risk assessments related specifically to these to ensure people took their medicines safely and there was no monitoring of the process. The provider's policy stated, 'Service users wishing to manage their own medication. Service users must be assessed on a regular basis.'

After the inspection we were informed by the provider immediate action had been taken and a trained staff member had been temporarily placed at the home from a sister organisation to administer medicines. Further training had been booked for staff on medicines on 27 July 2016. A meeting took place with a pharmacist to develop an action plan to address the shortfalls we found with medicines during the inspection. The provider also informed us that arrangements will be made with the pharmacist to implement the action plan.

During our last inspection the service was in breach of Regulation 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. The service had not completed risk assessments specific to people's health conditions and circumstances. During this inspection, we found some improvements had been made. Risk assessments had been completed for people that related to their health conditions. There were risk assessments for people with diabetes, stroke and high cholesterol, which provided guidance to staff on how to mitigate these risks in order to prevent it leading on to serious health complications. Risk assessment had been completed for people at risk of bruising due to blood thinning and for people who had osteoporosis, where the bone becomes fragile and brittle such as ensuring person exercised regularly and observing pain in the bone area.

Assessments had been made when people required support with moving and handling that listed people's ability to move, the support required and their height and weight. However, in five care plans out of the nine care plan we looked at we found that the height of the person had not been completed.

Staff members were aware of the risks to people around moving and handling and how to respond to escalating health concerns.

There were general assessments for everyone such as safety awareness, falls, unsupervised wandering, physical/verbal aggression and absconding. This had been completed on the care plans we looked at.

Falls risk assessment had been completed for most people at risk of falls. The risk assessment listed information on how to mitigate the risk of falls and also, where required, listed items such as walking aids to be used. We observed that people were supervised when they were mobile and supported on to walking aids. However, we found in two care plans that falls risk assessment had not been completed. One person had a history of falls and this had been identified as a risk on the moving and handling assessment. One person had osteoporosis and this could impact on the person's health should they fall. This potentially placed people at risk of harm. The provider told us both the people had not had falls since being admitted to the home and the falls history was in reference to their previous home. A falls risk assessment had been completed after the inspection using a scoring methodology which identified both the people were not at high risk of falling. Risk assessment for one person who was identified as being medium risk was completed and sent to us after the inspection.

One person, who had epilepsy, did not have a risk assessment on how staff should support the person, if they had a seizure. Epilepsy training had not been provided to staff on how to manage seizures. The provider told us that since the person had been admitted to the home, they did not have seizures and this was controlled through medicines, which was administered regularly. Basic training had been provided on how to manage seizures as part of the first aid training delivered to staff. The provider told us that arrangements were being made to deliver epilepsy training to staff.

Skin integrity was assessed using Waterlow charts to determine risk levels. Waterlow charts are a tool for assessing the risk of developing pressure ulcers. Records showed two Waterlow charts had been completed. However, records showed that a Waterlow chart was incomplete in one care plan. The Waterlow chart was not completed in full and did not determine if the person was at risk. We found that the person was at risk. However, no action plans or risk assessments had been completed to reduce the risk of skin complications. The provider told us that the person was not a high risk of skin breakdown and the person's skin is monitored regularly by staff when applying cream to the person's skin and any skin complications would be reported to relevant health professionals if required.

The above issues related to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Two people, two relatives and the staff we spoke to expressed concerns with staffing levels. One person told us, "They are very short staff" and another person commented, "No I don't" when asked if there were enough staff. A relative commented, "There is not enough staff on at weekends" and another relative told us, "The staff are running around like headless chickens. There is not enough. I see people wearing other people's clothes." One staff member commented, "There is few staff." The home employed four care workers during the morning, three care workers in the afternoon. The care workers were supported by a cook, a domestic staff and an activities coordinator. The manager also provided care and support to people. We observed the manager combined her substantive role as a manager and was involved in providing care and support and we saw her supporting people as well as doing managerial duties. This meant that the manager was not able to carry out managerial duties in full.

Some people were mobile and some people used walking frames for support. Some people's care plans stated that they required supervision when they were mobile. We observed that these people were unsupervised for periods of time. The manager and staff told us that more staff were needed during the day. We made a recommendation at the last inspection that formal needs assessment to be carried out to

determine staffing levels. We noted that the moving and handling assessment included the number of staff required to support people when they were mobile. At times, people required the support of two staff. We did not see evidence that needs assessment had been carried out for people that may require increased support due to their health conditions or behaviour. We fed this back to the provider, who informed us that people's needs would be assessed comprehensively and further staff would be deployed, if required.

The above issues related to a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Weekly fire tests and regular evacuation drills were carried out. Risk assessments and checks regarding the safety and security of the premises were completed.

We found that three people who lacked mobility were living on the upper floors and risk assessments had not been completed on what to do in the event of an emergency. As the people lacked mobility they were unable to use the stairs and neither the lift in the event of an emergency. Personal Emergency Evacuation Plans (PEEPs) had not been completed for these people. Staff had been trained in fire safety and were able to tell us what they would do in the event of an emergency. Fire doors had been installed that could withhold fire for 30 minutes. We did not see evacuation equipment had been installed to safely remove people during the inspection. The provider told us that evacuation equipment had been ordered and should be installed as soon it has arrived. The provider confirmed after the inspection, the evacuation equipment had been installed and staff had received refresher fire training on how to use the evacuation equipment and evacuate people safely. PEEPs had been completed for the three people that lacked in mobility living on the upper floors and the provider sent us evidence to confirm this.

Appropriate gas and electrical installation safety checks were undertaken by qualified professionals. Checks were undertaken on portable appliances and lifts to ensure people living at the home were safe.

Staff had been trained in safeguarding adults. Staff were able to explain how to identify abuse, the types of abuse and who to report abuse to. Staff also understood how to whistle blow and knew they could report to outside organisations such as the Care Quality Commission (CQC) and the local authority.

Staff files demonstrated that the provider followed safe recruitment practices. Records showed the provider collected two references from previous employers, proof of identity, criminal record checks and information about the experience and skills of the individual. Staff members were not offered a post without first providing the required information to protect people from unsuitable staff being employed at the home. The dates of the checks corresponded with the start date recorded on the staff files.

The home had a dedicated cleaning staff and we observed the home and people's room were clean and tidy. Staff used appropriate equipment and clothing when supporting people. People and relatives told us that rooms and the home was kept clean and tidy.

Requires Improvement

Is the service effective?

Our findings

People and relatives told us that staff members were skilled and knowledgeable. One person told us, "They [staff] never neglect what needs to be done. They just work harder. I think the staff have the patience of a saint" and another person commented, "We are pretty well taken care of." A relative commented, "My [the person] has advanced dementia. They do everything for her." A health professional told us, "They try to meet everybody's needs." Despite these positive comments we found that some aspects of the service were not effective.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA.

During our last inspection the home was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. We found that MCA assessments had not been completed in accordance with the MCA principles, MCA and DoLS training had not been provided and DoLS had not been applied for people that required supervision when going outside.

During this inspection, we found applications had been made for DoLS for people that required supervision when going outside. This meant that people were being deprived of their liberty lawfully.

Staff told us that they asked for consent before providing care and support and people and relatives confirmed this. A staff member told us, "We ask for consent, if they say no, we leave them and come back later."

However, training in MCA and DoLS still had not been provided. Two staff were not able to tell us the principles of the MCA and DoLS. We found that improvements had not been made with MCA assessments. In one care plan, we found that a MCA assessments had been completed that identified the person had capacity but did not include what area's the person had capacity in. Although the MCA assessment showed the person had capacity, a best interest decision was made by a family member.

We found MCA assessments had not been completed for three people. For people that self-administered their medicines, we did not see evidence that a capacity assessment was carried out to check if they had capacity to self-administer medicines.

There was a consent to care and treatment form. However, the forms had not been completed in full for four people. A best interest decision had been made for one person on the consent to care and treatment form without carrying out a MCA assessment. This meant the people's legal and human rights were not being adhered to.

The above issues related to a continued breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

During our last inspection the home was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. Some people's food was not being monitored and actions plans were not in place for people at risk of losing weight.

During this inspection we found nutritional assessments had been completed, which included what type of food people liked. Some people had high cholesterol and diabetes and we saw people's weight and food intake was being monitored regularly. We found five people had lost weight. We found food was being monitored for four of these people and regular meals were being provided. One person required weekly weight checks. The last weight recording was carried out on 16 June 2016 however, a referral to the SALT (Speech And Language Therapist) team had been made for the person.

One person was at risk of losing weight and a risk assessment had been completed on ways to mitigate the risk of malnourishment such as monitoring the person's food intake and ensuring they were on a healthy and balanced diet. We found food intake was not being monitored for this person. The person required weekly weight checks. The last weight check was completed on 12 June 2016. A Malnutrition Screening Tool (MUST), which is a screening tool to identify adults who are at risk of malnourishment had not been used to determine Body Mass Index (BMI) for people losing weight or at risk of losing weight. In two care plans, it was listed that two people would need their blood pressure to be monitored due to their health condition. However, the people's blood pressure had not been monitored or recorded.

In one care plan we saw that a person had a urinary tract infection. This person's fluid intake was not monitored and if they were taken to the lavatory regularly to prevent the risk of the infection developing.

The above issues related to a continued breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Some people told us that they enjoyed the food at the home. One person told us, "The food when it is cooking smells appetising. I believe it is always fresh food." However, some concerns were raised with food; one person told us, "I only like the Sunday roast. The menu rotates around and round. Never changes" and another person commented, "When I first came in here the food was very good, now it is not so."

We fed this back to the provider, who informed us this would be reviewed with the cook. Choices were offered to people and we observed that people were asked what they preferred prior to lunchtime. A person commented, "Yes, it is the right size portions for me and it is varied. They come in the morning to ask what I want." A relative commented, "[The person] is asked what [the person] likes. [The person] says "eggs & bacon" and this is what [the person] gets for breakfast." Staff confirmed people had choices, one staff member told us, "People have choices, cook goes around and gives them choices."

We conducted a Short Observational Framework (SOFI) during lunch time. A SOFI is a way of observing people and their interactions when they may not be able to tell us themselves. We saw that one person who needed support when eating was assisted and staff explained what they were doing and regularly interacted

with the person. People were not rushed and we saw good interactions between people and staff who communicated with people and encouraged people to eat when required. We observed that food was placed within easy reach of people and staff helped clean people's mouth, when needed.

During our last inspection the home was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. We found that staff had not received mandatory training to perform their roles effectively.

During this inspection we found, the service had systems in place to keep track of which training staff had completed and future training needs. Staff told us that they had easy access to training and found the training useful. Staff completed essential training that helped them to understand people's needs and this included a range of courses such as, basic life support, handling challenging behaviour, moving and handling and health and safety. Out of the six staff files we looked at, we found that five staff had not been trained in specialist courses such as dementia and diabetes. Six staff had not received training in equality and diversity and infection control. Dementia, equality and diversity and infection control were mandatory training, which was listed on the training matrix. Diabetes was not listed as a mandatory training, however some people had diabetes therefore it is important that training is provided to staff in diabetes. Although no formal training had been received in the aforementioned area's staff we spoke too had an understanding on the behaviours and limitations caused by dementia and the care and support people with diabetes will require such as ensuring a healthy balanced diet and engaging in physical activities or contacting a GP if glucose levels were to rise.

At the last inspection we found that appraisals had not been carried out with staff. During this inspection, we found that recent supervision had been carried out by the manager. Some appraisals had been carried out since the last inspection. However, the appraisal form did not list training and developmental needs listing aims and objectives for the year ahead. We fed this back to the provider and manager who told us improvements would be made.

Staff completed an induction to make sure they had the relevant skills and knowledge to perform their role. Induction involved a probationary period and covered all essential requirements that were needed to undertake the role. Staff confirmed they had induction training when they started the role.

The provider had made the home more dementia friendly, but further improvements were required. During the last inspection, we found that bedroom doors only had room numbers and no names or photos of people who were occupying them. There was also no directional signage around the home that indicated where the toilet was and the kitchen or a person's bedroom especially for those people living with dementia. Clocks in some rooms were incorrect. We observed one of the clocks in the lounge was also incorrect, and some calendars were from 2015. This is important to keep people with dementia orientated and in the present. There were two televisions within close proximity of each other playing different channels in the lounge, which made the lounge environment noisy and it was difficult to concentrate and confusing for people in the area. We made a recommendation that the provider seek advice from a reputable source on how to meet people's individual needs. During this inspection we found clock in the lounge were correct and one of the televisions in the lounge had been removed. However, there was still no directional signage around the home that indicated where the toilet was and the kitchen or a person's bedroom especially for those people living with dementia. The provider told us that plans were in progress to make the service more dementia friendly.

Records showed that people had been referred to healthcare professionals such as the GP, district nurse and dietician. Outcomes of the visits were recorded on people's individual's records along with any letters

from specialists. Records showed that people were supported to go to hospital when needed. Staff confirmed people had access to healthcare professionals particularly if they were unwell. They gave us examples of where they were able to identify if the person was not well and records confirmed this. One staff member told us, "You notice if they [people] are dizzy, if they are shaky, if not eating." One person told us "Yes, if I need it" when asked if they had access to healthcare. A relative told us, "[GP] has been to see my [the person]" and another relative commented, "The CHAT Team [Care Home Assessment Team], comes here every other week. This is very good service and means that either the resident or the family can chat to them. They also provide support to the home." During the inspection we observed a health professional visited the service to review people's health. The health professional told us, "They very much take on board what we say."

Good

Is the service caring?

Our findings

People told us they were happy with the care they received. One person told us, "Yes" and another person commented, "Oh yes" when asked if staff were kind and caring. A relative commented, "Yes, they [staff] are very caring" and another relative commented, "They [staff] are kind and caring."

Staff told us they built positive relationships with people by spending time and talking to them regularly. One staff member told us, "I usually sit down and talk to them." We observed that people were treated with care in their day-to-day care. People knew the names of staff and engaged in conversations related to a number of topics. On one occasion we observed staff responded immediately when a person was in difficulty and a staff stayed with the person until they felt better.

Staff had a good understanding about the people they cared for, in line with their care and support arrangements. Staff members were able to tell us about the background of the people and the care and support they required. They described people's behaviours, likes and dislikes and health conditions. One relative told us, "Yes, definitely and from my observations they know what resident's needs are."

Staff told us that they respected people's privacy and dignity. We observed that people could freely go into their rooms when they wanted to and close the door without interruptions from staff and people. Staff told us that they knocked on people's doors and waited for permission before entering.
Observations confirmed staff respected people's privacy and dignity and knocked on doors before entering. Staff told us that when providing particular support or treatment, it was done in private and we did not observe treatment or specific support being provided in front of people that would had negatively impacted on a person's dignity. A staff member told us, "We usually take them to their room when giving personal care and close the doors."

Staff told us that people were encouraged to be as independent as possible. We observed people were able to move around independently and go to the lounge, dining area, toilets and hallways if they wanted to. Staff told us that they encouraged people to be independent but only if they were comfortable.

We observed that staff treated people with respect and according to their needs such as talking to people respectfully and in a polite way. Records showed that people's identity and religion were recorded. Staff understood that racism, homophobia, transphobia or ageism were forms of abuse. They told us people should not be discriminated against their race, gender, age and sexuality and all people were treated equally.

Care plans listed how to communicate with people. For example, one person's plan listed that staff should speak slowly with a person as they have difficulty with hearing. Care plans provided detailed information to inform staff how a person communicated and listed people's ability to communicate. The provider should note that one person's communication care plan had not been completed.

End of life care plans were completed for some of the people and the involvement of their relatives were

clearly indicated and people's preferences were recorded.

Requires Improvement

Is the service responsive?

Our findings

Care plans included a summary of people's support needs, food preferences, healthcare issues, communication, personal hygiene and medicines condition that listed actions staff should take. Some care plans were personalised and person centred to people's needs and preferences.

During our last inspection the home was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. We found that some care plans were inconsistent and were not completed in full. We also found that reviews in some care plans contained limited information and did not reflect the changes in the previous month. During this inspection, we found some improvement had been made. Reviews of care plans had been carried out and these reflected changes from the last review.

In one care plan, we found a person had depression. Important information such as physiological and communication had not been completed. This meant that staff may not have important information to provide personalised care and support to the person.

We also found two instances where people had been taken to the hospital and a discharge and a transfer form had not been completed to ensure continuity of care where the person moved between services, which meant the hospital potentially did not have information to provide the right care and support.

The above issued related to a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

We found that care plans were not being completed in full. In five care plans, there was a 'my care plan summary', which summarised people's needs and preferences throughout the day and how they liked to be supported. There was no care plan summary in four care plans. Ensuring care plan summary for people would help staff especially new staff provide a summary of people's daily routines and care needs enabling staff to get a better understanding of people's needs and support.
There was a shower and hair wash chart for one person due to a specific health condition. The chart listed that the person required a regular shower and hair wash. We found that the chart was last completed on April 2016. The provider told us that the person does have regular showers and their hair washed and staff may have failed to record this.

People were assessed before being admitted to the home in order to ensure that their needs could be catered for. Admission sheets confirmed that detailed assessments of people's needs were undertaken, including important aspects such as the medicines they were prescribed and their diagnosis.

We did a random test on the call bells with the provider on each floor to check the response by staff members and found staff response was within an appropriate time. This meant that people could receive immediate attention should the need arise by using the call bell.

There was a daily log sheet and communication book, which recorded key information about people's daily

routines such as behaviours and the support provided by staff. We observed that the information was used to communicate between shifts on the care people received during each shift. A relative told us, "In 2014 my [the person] was hospitalised. [The person] was distressed in there. But when [the person] come back here [the person] mood changed dramatically and was more compliant and restful. So I know that was a good sign."

Records showed complaints were made by people or their family members since the last inspection. We found that two complaints had not been investigated. We fed this back to the provider, who assured us that the complaints had been investigated by the previous manager but the actions had not been recorded. The provider should note that two people and one relative told us that they had expressed some concerns about the service and appropriate action had not been taken. The provider told us that this may be due to the concerns not being raised formally as all formal complaints were investigated in full with a response and the concerns may have been raised with the previous manager, who had left. A relative told us that they had made a complaint and this was investigated and action taken. When we spoke to the staff member on how they would manage complaints, they told us that they would record the complaint and inform the manager and deal with the complaint as much as possible.

The above issued related to a continued breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

During this inspection, we found there was a programme of weekly activities. Observations confirmed people participated in activities such as dominoes, games and bingo. There were pictures and painting around the house that evidenced people took part in creative artwork and carried out activities. We observed the activities coordinator going to people's room to participate with individual activities. The activities coordinator told us that she would do individual activities with people who did not like to participate in group activities. We saw records that people were able to go outside. One person told us, "I have been out on the coach a couple of times where we stop for lunch and then home again. That is what I like."

Inadequate

Is the service well-led?

Our findings

We observed people interacted well with each other, chatting and laughing with staff. One person told us, "I am happy here." A relative told us, "My [the person] is so happy and settled here, we so want her to stay." Staff told us the culture within the home is like a family but had concerns about staffing levels as they felt this was not being addressed and they were unable to take breaks regularly, which may impact on the culture of the home.

However, the provider had failed to ensure that adequate quality assurance and systems were in place. No quality assurance, such as internal audits, had taken place since the last inspection under two different managers. An audit carried out by an external pharmacist had identified many of the issues we identified, but no action had been taken. Although the home had carried out an annual satisfaction survey of people who used the service and visiting health professionals, no analysis of the findings of these surveys had taken place. The results were not being used to make improvements to the service to ensure high quality care was being delivered at all times and there was no culture of continuous improvement.

During the last inspection we found seven breaches that required by law a written report of the action that the provider was going to take to meet the Health and Social Care Act 2008, associated regulations and any other legislation we have identified the service was in breach of. The provider failed to send this to CQC.

During this inspection, we found widespread shortfalls (eight breaches of the regulations in total), some of which were continued breaches. Compliance with one of the regulations (medicines management), which the provider was in breach of at the last inspection, was substantially worse at this inspection. The provider had failed to ensure that, despite the change of manager since the last inspection, appropriate systems were in place to address the previously identified shortfalls and to prevent additional breaches of the regulations from occurring.

The provider had failed to ensure that there were adequate resources and roles and responsibilities within the service were not always clear. People and staff said that there were not enough staff available to meet people's needs. The provider and manager recognised that more staff were needed during the day. The recommendation we made at the last inspection that formal needs assessment should be carried out to determine staffing levels had not been acted upon. The provider had failed to ensure that all staff had mandatory training required to perform their roles. The role of the manager combined managerial and significant caring duties, which has an impact on the ability of a manager to manage the service effectively.

During the inspection we provided feedback to the manager and provider on the shortfalls we found during the inspection. Immediate action was taken after the inspection to address some of the shortfalls found during the inspection. However, due to the lack of progress in addressing the breaches in the regulations and the further breaches we have identified, we lack confidence in the provider to be able to ensure that improvements are sustained and embedded.

Records were not always kept up to date. We found the care plan records such as the care plan summary,

shower and hair wash chart and discharge and transfer form had not been completed in full. Risk assessments had not been completed in full in order to ensure staff had the relevant information to provide high quality care at all times and the actions taken for two complaints had not been recorded. Correct process had not been applied to record administration, supply and disposal of medicines.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

We reviewed information we held about the service prior to our inspection and noted that no statutory notifications had been made to CQC in respect of outcomes to DoLS applications. When an authorisation for DoLS has been granted, it is a requirement that the home inform CQC. During the inspection we found that DoLS authorisation had been granted for eight people and the CQC had not been notified of the outcome. The manager told us that notification will be sent to the CQC.

This was in breach of Regulation 18 the Care Quality Commission (Registration) Regulations 2009.

During our last inspection we found that residents meeting had not taken place since November 2014 and staff meetings had not taken place since April 2015. We found improvements had been made during this inspection. A resident meeting took place in May 2016 and records showed residents were able to discuss and provide their thoughts on activities, menu and mealtimes. Staff meetings were held in January and May 2016. Topics included complaints, medicines, teamwork, infection control and updates on people. Minutes were available from both meetings.

People and relatives did, however, speak positively about the management of the home. One person commented, "She [manager] is quite friendly. She comes round and talks to you." We observed the manager assisted people when asked and the interactions were friendly and caring.

Staff were positive about the management. A staff member commented, "She [manager] is approachable, she listens."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified about significant events affecting people's care and support needs in relation to the outcomes of Deprivation of Liberty Safeguarding outcomes. Regulation 18(4)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Assessments of the needs and preferences for care and treatment were not carried out in full for some people that used the service. Regulation 9(1)(3)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided with the consent of the relevant person as the registered person was not always acting in accordance with the Mental Capacity Act 2005. Regulation 11(1)(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

The service provider was not providing care in a safe way as they were not doing all that was reasonably practicable to mitigate risks to service users.

Regulation 12(1)(2)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs In order to reduce the risk of harm from malnutrition or unexpected weight loss the service should ensure that they appropriately record diets and take action at the right time to keep people in good or the best of health. Regulation 14(1)(4)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered provider failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by relatives. Regulation 16(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not comprehensively assess the needs of people to sufficiently deploy suitably qualified, competent, skilled and experienced persons. Regulation 18(1).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service provider was not providing care in a safe way as they were not doing all that was reasonably practicable to ensure the safe management of medicines Regulation 12(1)(2)(g).

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider was not assessing, monitoring, improving the quality and safety of the service users and mitigating the risks relating to the health, safety and welfare of service user's who may be at risk which arise from the carrying on of the regulated activity. Regulation 17 (1)(2)(a)(b). The provider had not maintained securely an accurate, complete and contemporaneous record in respect of each service user. Regulation 17(1)(2)(c)

The enforcement action we took:

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